Meeting millennium development goals 3 and 5

Gender equality needs to be put on the African agenda

A recent World Health Organization report warns that the health related millennium development goals (MDGs) will not be met without a dramatic increase in investments in national health systems.[1] Assessments of progress towards the goals to date have found that we have made the least progress towards MDG 5—to improve maternal health—particularly in sub-Saharan Africa. In some African countries the situation has got worse; maternal mortality in Malawi has almost doubled between 1992 and 2000 despite increased resources for health.[2] Women's lifetime risk of pregnancy related death in Malawi is now 1 in 7, compared with 1 in 2800 in industrialised countries.[3] It is critical and timely to lobby for more resources, but this is insufficient without attention to the issues of gender and power which underlie maternal morbidity and mortality, both within communities and within health systems.

Every minute, a woman dies in pregnancy or childbirth.[4] Nearly half of these deaths (47%) occur in Africa, and the vast majority are avoidable through skilled care in delivery and access to emergency obstetric care.[3] For every woman who dies because of obstetric complications, 30-50 women suffer morbidity and disability.[3] MDG 5 rightly focuses attention on urgent action to address this unacceptable situation. It is widely agreed that the high maternal mortality ratio in many sub-Saharan African countries is a reflection of the status of women in these societies, since it vividly illustrates how acceptable a society finds such avoidable deaths.[3] Meeting goal 5 is therefore inextricably linked to meeting goal 3—to promote gender equality and empower women.

The links between gender inequalities and maternal morbidity and mortality in sub-Saharan Africa are many and often unrecognised. The low priority accorded to girls' and women's wellbeing throughout their life cycles contributes towards poor nutrition and ill health, which increase the health risks to women in pregnancy and childbirth.[5] Women's lack of control over their reproductive capacities and exposure to violence further intensify these risks through early, multiple, and unwanted pregnancies.[6] Low levels of education and literacy, access to and control over resources, and limited autonomy within the family and community limit poor women's ability to use healthcare services in pregnancy or delivery.[7] Even if these women reach services, healthcare providers are often uncaring, judgmental, or abusive, which stems from broader health system failures.[8] Women's poor health and low control over their reproductive capacities in turn exacerbate gender inequities—for example, girls are often withdrawn from school to care for sick family members.

Failure to address these gender dimensions adequately is an important reason why we are falling so short of meeting MDG 5 in Africa. Women's rights to control their bodies remain a battleground between a religious conservative alliance and the radical vision of social change laid out in the agreements made at the landmark conferences on population policy in Cairo (1994) and on women in Beijing (1995). The multiple interconnections between women's rights and maternal morbidity and mortality point clearly to the need for access to the full range of sexual and reproductive health services outlined in the Cairo and Beijing agreements, in order both to improve maternal health and to reduce the maternal mortality ratio by three quarters. However, the goal of access to reproductive health services for all people of appropriate ages was removed from the final millennium development goals, due to pressure from an alliance of social conservatives led by the United States.[9] This powerful lobby is also active in campaigns to undermine implementation of existing sexual and reproductive health programmes, for example by removing contraceptive provision from programmes to prevent obstetric fistula.[10]

Another reason for falling short of meeting the goals is the negligence of the world's richest countries and African governments in failing to commit sufficient resources to meet women's rights for reproductive health. Maternal health services are chronically underfunded.[11] Money is not enough, however. Translating resource commitments into concrete improvements in the lives of women requires a commitment to gender equality within and beyond the health sector; this threatens many vested interests and will therefore require new alliances to be forged within and beyond African states to drive change. Participatory approaches to making responsive relationships between health sector actors and poor women (relationships that seek to engage men) are crucial to ensuring the development of quality, accessible, and accountable health services.

Action for gender equality beyond the health sector is also vital to meet not only MDG 5 and MDG 3, but all the millennium development goals. Meeting the target of eliminating gender disparity in primary and secondary education would contribute towards the goal of gender equality but will not enable us to reach it. There is an urgent need to take a holistic approach to achieving gender equality and women's empowerment, including guaranteeing women's property and inheritance rights, reducing discrimination in labour markets, increasing women's representation in political bodies, and ending violence against women.[12]

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Medicines supply in Africa

Should improve through regional collaborations and accredited drug shops

Lack of access to medicines each year contributes to millions of deaths and untold suffering in Africa. HIV/AIDS, tuberculosis, and malaria—all treatable with existing medicines—kill an estimated 6 million people every year, mostly in sub-Saharan Africa.[1] The burden falls mainly on the poor, women, and especially children.[2]

Over the past three decades, African governments have worked to provide medicines to populations with growing health needs. During that period the World Health Organization has advocated increasing access to medicines[3–5]; the World Bank has pushed for reforms in the health sector; and Unicef has launched the 1987 Bamako Initiative, meant to improve communities' access to pharmaceuticals. Despite these efforts, WHO estimates that roughly 270 million people in Africa—nearly half the population—lack regular access to even the most essential medicines.[6]

Poverty, diverse geography, and social upheaval all contribute to the problem of access. The public sector's supply systems are plagued by inadequate financing, weak management systems, lack of accountability, and a devastating reduction in the healthcare workforce.[7] The formal private sector is generally limited to urban areas. Faith based and other non-governmental services supplying health care are often well run, but typically handle less than 15% of a country's pharmaceutical market.[8]

In this context, tinkering with existing models of supply is unlikely to close the huge gap in access to medicines. Policy makers, health officials, and others concerned with improving health in Africa must find new solutions. These may include overhauls of policy, financing, and frameworks for regulation; a realignment of responsibilities between public and private sectors; and the forging of genuine public-private relationships to help in implementing the supply of medicines.

The first source of medicines in much of Africa is the corner kiosk or other informal drug seller. Though these sources are easily accessible, customers often receive inappropriate medicines of poor quality. Tanzania—where such shops provide medicines for over 60% of the population—has developed a system of accredited "duka la dawa muhimu" (essential drugs shops). Staff are trained in dispensing and business skills, and shops are now regularly inspected and reliably supplied with registered medicines. Dispensing recommendations and the availability and quality of products have improved more in the accredited shops than in informal shops.[9] Innovative public-private franchising and accreditation have also been introduced successfully in Ghana and Kenya and are being developed in Nigeria and elsewhere. Considerable effort is needed if such schemes are to maintain dispensing practices that contribute to health improvements, provide access to the poorest of the poor, and ensure financial and managerial sustainability.

African countries need to develop integrated systems for the supply chain that fully use the capacity of the public, non-governmental, and commercial sectors. One approach is the primary distributor model,[10] whereby the government contracts that private companies will operate the pharmaceutical supply chain, while it provides contractual oversight and controls the procurement process. Another approach allows private or non-governmental systems to supply a particular area or specific health facilities. Such innovative public-private relationships have been implemented on a small scale in several African countries, including Zambia, South Africa, Tanzania, Kenya, and Uganda. However, such efforts fail to improve the supply of medicines if the private sector is weak, lacks independent management, or is insufficiently accountable.

Africa's regions could use economies of scale to buy medicines and assure their quality. Similar needs for medicines, shared sources of supply, and lack of national expertise in procurement all argue for greater collaboration among neighbouring countries. Regional partnerships might include sharing information on pricing and suppliers, establishing formal group purchasing schemes, and contracting with commercial distributors to supply health programmes throughout the region. The Southern Africa Development Community, the West Africa

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